

## **ABSTRACT**

The following paper is the first in a series of three papers to highlight current practice among governing body nurses, that is, nurses who hold the statutory role of nurse member on clinical commissioning groups in England. In this paper we present findings from a small pilot study into these nurses' experiences of Clinical Commissioning Groups. Their roles have emerged at a time of organisational change and in a period following extensive criticism of nursing and nurses in the media. We suggest that nurses' roles and experiences are affected by these contextual 'events' and by the emerging structures and diversity of clinical commissioning groups. We argue that governing body nurses' effectiveness in leading nurses and nursing on clinical commissioning groups may be affected by their relationships with other nurses, especially senior nurses, within clinical commissioning group localities. We suggest that it is timely to evaluate the effectiveness of statutory nurse member roles in influencing decision making on Clinical Commissioning Groups.

## **INTRODUCTION**

As part of a restructuring of the NHS, Clinical Commissioning Groups (CCGs) took over the design and commissioning of health services in England in April 2013. Significantly, each CCG appointed a Clinical Member Registered Nurse to its governing body. This new role, now referred to in practice as the governing body nurse (GBN), potentially offers important opportunities for nurses to shape patient-centred service delivery and ensure diversity within clinical leadership.

This paper explores findings from a pilot study conducted into the experiences of a small sample of GBNs in the South East of England. The aims of this study in 2014, a year after CCGs went live, were to establish the backgrounds and explore the experience of GBNs being appointed to CCGs; the ways in which they carry out their responsibilities; their perceived effectiveness in ensuring safe, patient-centred care, and the factors that influence this, in order to identify how GBNs can be best supported.

## **BACKGROUND**

According to the NHS Commissioning Board, (April 2012) GBNs are expected to bring an independent and strategic view on all aspects of CCG business. Guidance from the Royal College of Nursing (2011) suggests that the role requires a senior level appointment; beyond contributing a nursing perspective, appointees should have experience of commissioning, service re-design and the safeguarding and monitoring of standards. However, little is known of how nurses function at this level (Burdett Trust for Nursing 2006), what the demands of the role will be or what learning and support needs might arise. Evidence from nascent or 'shadow' CCGs suggests that, of GBNs appointed so far, few have the relevant experience to meet the needs of a strategic role (West 2012). Until very recently, many CCGs were appointing practice nurses to the role, despite concerns of insufficient experience, and a conflict of interest between the needs of their employing GP practice and the CCG governing body (NHS Commissioning Board, April 2012). Additionally, many GBNs have no proper job description; too little time to carry out their responsibilities; little management support; and unequal access to training,

development, formal support or supervision compared to their GP colleagues (West 2011).

## **METHODS**

This pilot project used mixed methods in four phases: literature review, qualitative data collection (interviews), quantitative data collection (survey). Phases 1 - 3 were discrete data collection exercises as well as means of developing the questionnaire. Phase 4 integrated the data analysis from phases 1 – 3 in a final data analysis phase.

### **Phase 1 - Literature review**

The questions for the review were:

- What is the function and role of CCGs' governing and operational structures?
- What is the guidance on the role and competencies of GBNs?
- What is known of how senior nurses reconcile nursing values with the strategic aims of service delivery, such as commissioning, efficiency, and value for money in similar strategic level roles?

The following databases were used: BNI; CINAHL; Cochrane Library; ISI web of knowledge; Medline (Ovid) & Medline Pubmed; MIDIRs; PsylInfo; Social Science Citation Index; Caredata; Index to theses. The grey literature was searched, i.e. research reports; Department of Health [DH] policy documents. The inclusion criteria were as follows: all English language literature nationally and internationally from 1997 onwards until 2014). Beginning the review in 1997 allowed a review of research and policy on the emergence of senior nursing leadership roles since the New NHS (2000). The focus of the literature and policy was restricted to the UK. 38 relevant reports and papers were reviewed.

## **Phase 2**

This phase included two focus groups with six GBNs, and four individual interviews with four other GBNs during April-June 2014. The interviewees were asked about employment status, skills and previous experience, job description and the key factors that hinder or facilitate their full contribution to the governing body's work. Both focus group interviews were held at NHS offices and individual interviews conducted either at in participants' offices. Focus groups lasted between 90 and 110 minutes, individual interviews were between 60 and 75 minutes. The interview schedule was developed from the literature review by the researchers and the advisory board. Interviews were semi-structured. All focus group interviews and two individual interviews were transcribed verbatim by an outside transcriber. Two remaining interviews were listened to and notes made on their content as data saturation was felt to be reached. Thematic analysis was used to analyse the transcripts along with analytic memos and interview notes made by the interviewer [HA]. Findings from phases 1) and 2) were integrated to construct the items for the survey in phase 3.

## **Phase 3**

The third phase was the development and piloting of an online questionnaire within the South East of England. An online survey invitation was distributed via the surveymonkey platform to a list of 22 GBNs in this region. A 'census' sampling approach was used, meaning that all of those on the list were invited to take part. Three reminders were used and 12 responses were obtained giving a response rate of 54.5%.

Quantitative data were analysed in SPSS v21 and Excel and open questions were analysed thematically. The survey data were analysed separately and then findings from all three phases were integrated in a final data analysis phase.

## **ETHICS**

Ethical review was obtained from Middlesex University. Access to the potential participants was gained through local NHS contacts. An invitation letter and information sheet about the study was sent to each participant. Informed consent was obtained along with permission to digitally record interviews.

## **FINDINGS**

We present the findings from the three phases separately as they all elicited distinct findings which are integrated in the discussion later in the paper.

### **Phase 1 - Literature review**

Some interesting findings emerge from the literature published since April 2013 when GBNs were first in post. As referred to earlier, West (2011, 2012, 2013) found that few of the GBNs appointed in the earliest stages of the formation of CGs had the relevant experience to meet the needs of a strategic role and many GBNs had no proper job description; too little time to carry out their responsibilities; little management support; and unequal access to training, development, formal support or supervision compared to their GP colleagues (West 2011). Early on, the King's Fund (2013) suggested that engagement was lower amongst non-GP members of CCGs, and a common

reason for this was the perception that 'all the attention is focused on GPs'.  
(King's Fund 2013:26).

While the picture appears to be changing, e.g.: Olphert (2014) cites Trevithick's MA thesis (2014) to argue that CCG board nurses have begun to show their value to their GP colleagues in terms of quality and safety assurance. Yet the BMJ (2013a) reports that GP conflicts of interest are 'rife' and given the dominant role of GPs on CCGs this might be another factor limiting the influencing ability of the GBN and doubts have been expressed about how much freedom CCGs will have in view of targets from NHS England (Shapiro 2014; BMJ 2013b).

NHS England commissioned a survey of each CCG and its stakeholders in March/April 2014 (IPSOS MORI /NHS England 2013). The results must be treated with caution as probability sampling was not used; CCGs could choose to nominate respondents from amongst stakeholder groups or partners and the results could therefore be extremely unrepresentative. At the time of writing it is not possible to disaggregate the responses of GBNs from those of other CCG stakeholders. An informal examination of the survey questions, where national averages are provided, suggests that members of CCGs, stakeholders and partners report that they are working reasonably well, that they have a good working relationship with the CCG and that they feel listened to. However there are aspects of CCGs which respondents are considerably less positive about; less than 60% agreed that their CCG can

deliver continuous improvements and just over 50% agreed that their CCG had acted on their suggestions).

Perhaps this perceived lack of impact is partly because, as Shapiro (2014) puts it:

*“CCG leaders found themselves the late arrivals at a party in full swing. NHS England had already established the ground rules, subsumed specialist commissioning and primary care, and determined how CCGs should work and be managed”.*

It is likely that the role of the GBN may still be in flux and it is unclear at this stage how effective GBNs will be now the role is defined and embedded in CCGs.

## **Phase 2 - qualitative data**

Three core themes emerged from the interview data: the extent to which CCGs differ from other NHS structures; the main models of work of governing body nurses; and the extent to which this role provides an opportunity to shape nursing and provide nurse leadership. These form discrete findings while at the same time informing the survey items.

### *Theme 1: CCGs are different to other NHS structures and each other*

The interview participants emphasised that CCGs are different to other structures within the NHS and also worked differently to each other. Equally interviewees were careful to say that his/her way of performing was the best for their circumstances reflecting the need for each CCG to respond to pressures and structures within their locality.

*“There's a kind of balance of being locally the right fit for the local CCGs which are all different and dynamic in their own way and are different sizes” (FG1)*



These differences were felt to be partly due to CCGs being an unknown entity,

“But I don’t think we all really – I’m not just talking about us but the world – really gets what CCG governing boards should or really could do that’s different to what PCTs [did]” (FG1)

Importantly perhaps, all the interviewees reflected on the contextual difficulties for CCGs, such as “a constantly changing landscape” (Int 1). And all of the participants emphasised that the role of the GBN as a member of the CCG Board or governing body was to focus on the strategic direction and not the operational detail,

“Not getting lost in the detail as nurses are trained to manage the detail, even DoNs [Directors of Nursing] do this, how many staff on duty on ward xxx tonight. You don’t need those skills, in fact, you have to lose some of those skills” (Int 3)

Another contextual factor was the influence of the Francis Report (2013) which had made the risks of poor quality “all too evident” (Int1). It was suggested that the fall out of the Francis Report had changed debates around quality and an increased concern with accountability in the CCGs, bringing an “over-focus on assurance and not on improvement and quite a fear culture” (FG1).

#### *Theme 2: Models of GBN work*

Two working patterns or models of GBN work emerged: the full time integrated executive/statutory (GBN) role and the part time (2 sessions per month) non-executive/statutory (GBN) role. In the latter role, role holders typically held other posts elsewhere in either the NHS or other health-related organisations. One GBN was semi-retired although he had several other part time health advisory roles at a senior level. However the full-time role was not

altogether consistent. Int 1 described her executive/statutory role as an integrated role; that is integrating the GBN statutory role with other functions of a nursing or quality remit, i.e.: the Director Nursing role. Int 1 said having this integrated role had helped strategically to increase the credibility of nursing across the locality. However her remit for five CCGs was the only example of a GBN holding more than one GBN role. Int 3 worked full time on *one* CCG as the GBN with a broad remit for nursing, quality, corporate development and commissioning in his executive or Director of Nursing role. It is not entirely clear from the data what the different models of nurse involvement in CCGs are or what the key determinants of CCGs opting for one or the other model might be.

There were different views about the two models. In FG2 the participants both worked as part time statutory GBNs (albeit with different titles and roles). One felt that combining the statutory and the Director of Nursing role would not be beneficial,

“Some of them [CCGs] have actually combined the two roles and there are advantages in that obviously you know what’s going on all the time in the CCG. But then..... You know our chief officer always says that in a way it’s good to have the role separate because you are keeping your powder dry.” (FG2)

The issue of CCG Board members being part or full time has implications for who might consider applying for positions, both in terms of those free and able to consider part time work, i.e. the retired or more affluent; and those practicing and working within the same locality. Int 3 considered that,

“The exec role in my view is more about effecting change and leading nursing. There are two models which developed because of local circumstances. The retired, non-exec roles are a real worry in that respect

as we are so managerially and organisationally thin...no natural successor to my role and the age-gap is very real”

It was unclear whether this was an issue for CCGs as a whole or more specifically an issue for GBNs.

Int 3 was keen to point out that by working part time in non-executive roles, nurses might be missing an opportunity to lead change and nursing but that the part-time roles suited what was effectively an ageing workforce in nursing management. But even more important was the requirement for Board members not to be practicing in the same locality as the CCG. As a consequence some CCGs had found recruitment difficult and had combined CCG boards,

“And some of the CCGs to get round it, advertise the posts of say three CCGs together to try and so that it gave people a bit more of a substantial role” (FG2)

However part-time status was perceived by FG2 participants to be a positive feature of the CCGs as the part-time role was seen to increase scrutiny as they felt independent or external to the CCG executive. Int 2, a part time GBN, described herself as a lay member but in what sense was unclear,

“More like a lay member and use my role as a nursing voice, an external voice to the locality”

### *Theme 3: Leading nursing/being a leader of nurses*

The degree to which GBNs should or could be a lead for (the profession of) nursing within the CCG locality was a subject the interviewees felt strongly about. For so me, “they [nurses] were on the board to hold the professional responsibility and to advise the governing boards” and they had a “very strong

nursing voice” (FG1). But the participants in FG2 felt that all Board members were leaders for strategic change,

“All of the roles on the Governing Body are around providing leadership and strategic leadership vision all of that kind of stuff from a health perspective for the health and social care,” (FG2)

When pressed, both participants in FG2 replied,

“Yeah you will be rolled out for key note speeches or that sort of thing because of your leadership role and your nursing role” (FG2)

Int 1 saw nurses “as best placed due to their training, their holistic view, their whole system working and their patient focus”. Int 1 was a Director of Nursing and believed she had credibility as a nurse leader. Without this executive power and an ‘active, proactive board role’ nursing would not have voice or presence. She compared it to the PEC (Professional Executive Committee) role on PCTS which had answered to the PCT and therefore had no voting power on the PCT. She, as Director of Nursing on the CCG, did have power through her voting rights. But crucially the voice and therefore the power came from knowledge of the subject matter, i.e. health and nursing.

Of course being the professional lead in a locality depends on the relationships of the GBN with other nurses external to the CCG board for credible leadership. GBNs’ relationships with DoNs in the local provider organisations were crucial to how they understood their leadership role and how effective CCGs might be in leading nurses,

“Provider chief nurses don’t always understand about commissioning or the intricacies of commissioning, therefore think that it’s a bit of a mystery ... but I think a lot of it’s personal – now, at this point in time, it’s about personal credibility” (Int 4)

The roles were mutually dependent for their respective success:

“Despite tricky conversations about quality, I'd be nervous if I didn't have those relationships because I get assurance about quality to enable me to speak in front of say, patient groups. And DoNs need me because otherwise they'll be talking to a contracts person”. (Int 3)

### **Phase 3 – survey**

We present some demographic data initially to indicate how homogenous the respondents were, followed by respondent profiles which gives a picture generally of the types of experience which GBNs brought to the role. Then we present five core themes in the survey findings. The n for all survey questions is 11 except where otherwise indicated.

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#### *Respondent demographics*

The demographic data are of interest as they reveal a striking homogeneity amongst respondents in terms of gender, age and ethnicity; 81.8% of respondents (n=9) were female and just over two-thirds (63.6%, n=7) were aged 50-59 with a further 18.2% (n=2) aged 60-65. Just 18.2% (n=2) were under 50 and there were no respondents younger than 40. The vast majority of respondents were White or White British but 9.1% (n=1) were Black Caribbean and the same proportion were White Irish. Survey data was not crosstabulated on the basis of demographic variables as this would not be appropriate or meaningful with such a small number of responses.

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#### *Respondent profiles*

A majority of respondents (54.6%, n=6) had been in their post for 24 months or more. Just 18.2% of respondents (n=2) had been in post for six to 12 months and no respondents had been in post for less than six months. This would seem to be positive for the validity of the survey in terms of obtaining the views of people who are settled into their post and so are able to give considered opinions rather than respondents who are new in post and likely to be on a steep learning curve.

~~A majority of respondents (54.6% n=6) had been in their post for more than 18 months. Just 18.2% (n=2) of respondents had been in post for six to 12 months and no respondents had been in post for less than six months. This would seem to be positive for the survey in terms of getting the views of respondents who are settled into their post and so are able to give considered opinions rather than those who are new in post and likely to be on a steep learning curve.~~

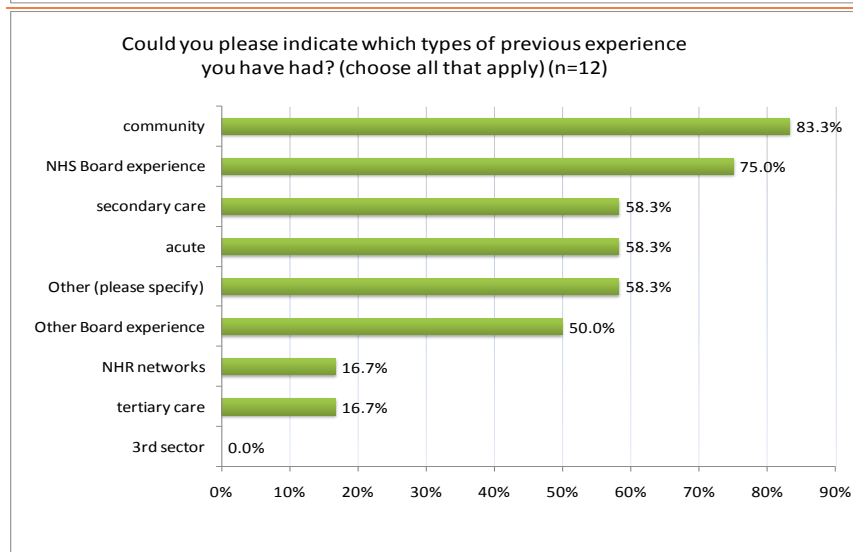
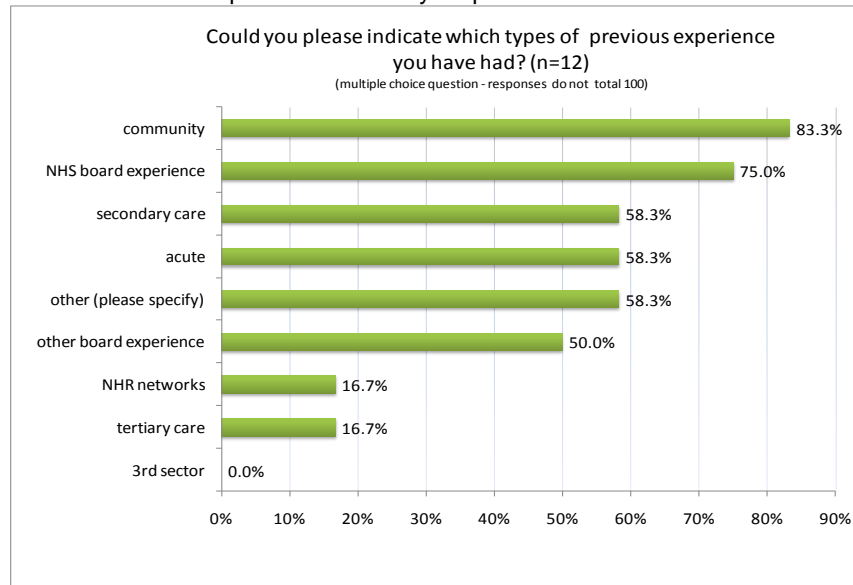
experience, three-quarters (n=975%, n=9) had NHS Board experience and a majority (58.3%, n=7%, n=7) had secondary and acute experience. Half of respondents (50%, n=6) had ~~had~~ other board experience.

The vast majority of respondents (83.3%, n=10, n=40) had had community nursing experience, three-quarters (n=975%, n=9) had NHS Board experience and a majority (58.3%, n=7%, n=7) had secondary and acute experience. Half of respondents (50%, n=6) had ~~had~~ other board experience.

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<sup>‡</sup> As stated earlier, the n for respondents (as shown in charts) is 12 throughout unless otherwise stated.

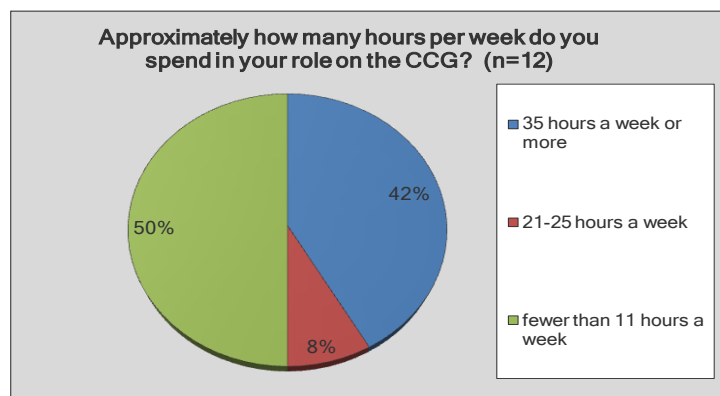
Chart 1: Previous experience of survey respondents





*Theme 1: Models of GBN work*

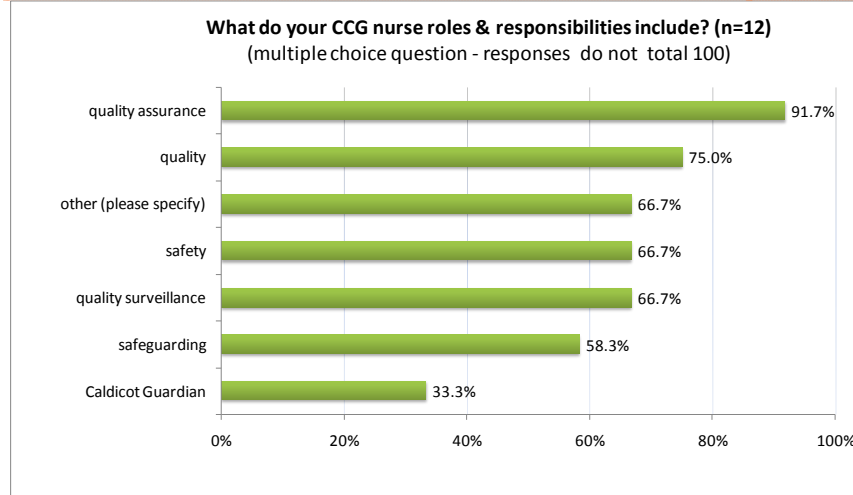
Chart 2: Number of hours per week respondents worked in CCG role



There seemed to be a sharp divide in working patterns as half of respondents (50%, n=6, n=6) spent fewer than 11 hours a week in their CCG role and just under half more than four in ten (41.7%, n=5, n=5) spent 35 hours a week or more. The remaining 8.3% (one respondent) said that they were spending 21-25 hours a week in their CCG role. This is perhaps surprising since the CCG board nurse role is envisaged as full time by the RCN (2011). This polarisation of working patterns may well be explained by the 'two models' identified in the qualitative research; the full time integrated executive/statutory (GBN) role and the part time (two sessions per month i.e. two days) non-executive/statutory (GBN) role. This was explicitly identified by one survey respondent:

"There are two distinct roles with the option for a full time exec-type role merging later as part of the CCG assurance"

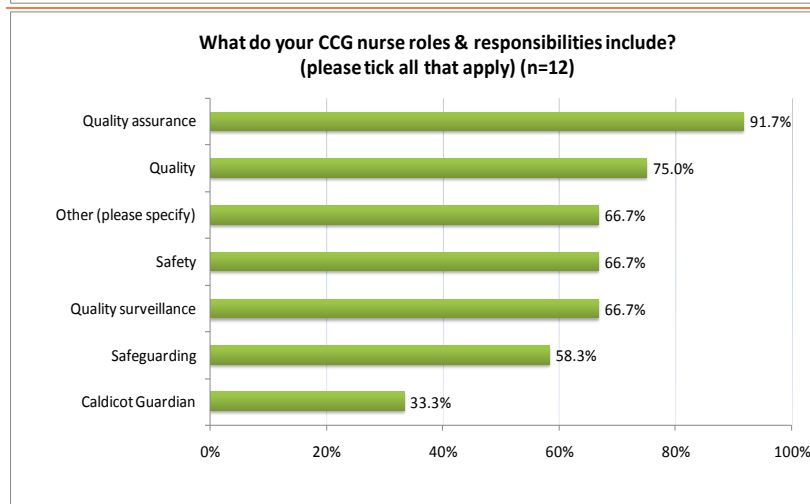
Chart 3: what do your CCG nurse roles and responsibilities include?



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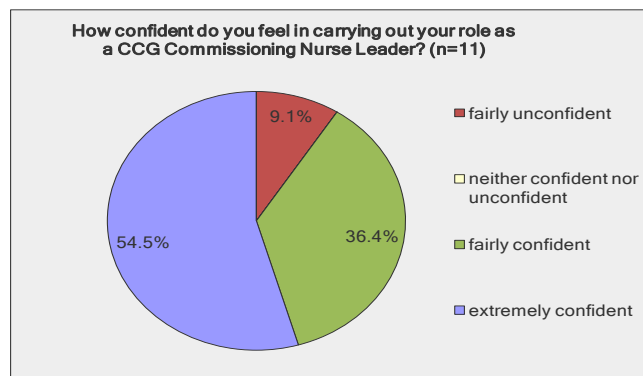
Quality and quality assurance were the most frequently cited roles or responsibilities of the respondents with 91.7% (n=11) choosing the former and 75% (n=9) choosing the latter. Workforce development was the most salient theme amongst the other responsibilities or roles mentioned by respondents.

*Theme 2: Reasons for wanting to become a GBN nurse*

The reasons given for wanting to be a GBN nurse were quite varied; the most common reason given was the wish to use relevant experience and to ensure a nursing input into the CCGs to improve care. Several respondents mentioned that the CCG role fitted well with their retirement or semi-retirement and several respondents wished to gain or develop commissioning experience. Respondents highlighted the importance of making a nursing input to CCGs as distinct- from ~~both-either~~ a clinical governance or medical input. In open ended responses the core elements of the statutory nurse role in the CCG board were most often associated with ensuring a nursing perspective or voice is heard when commissioning decision making-, ensuring that quality ~~(mentioned by six respondents)~~ and safety in patient care were priorities for the CCG and generally contributing to good governance.

### *Theme 3: Confidence and impact*

Chart 4: Confidence about carrying out GBN role



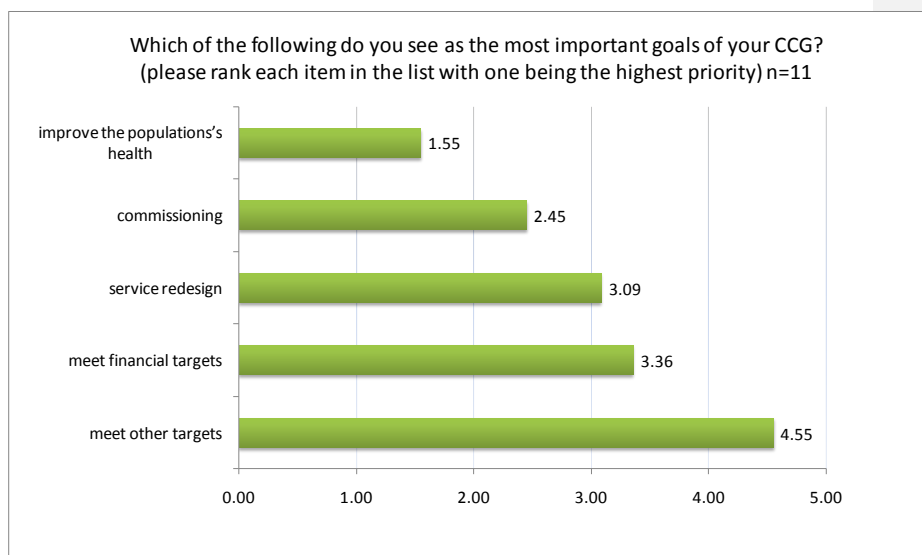
90.9% of respondents (n=10) were either 'extremely' or 'fairly' confident in carrying out their role as a CCG commissioning nurse leader. No respondents chose 'not at all confident'. Most respondents said that they felt more confident at the time of the survey than when they started in post.

A majority of respondents (58.3%, n=7) felt that the statutory nurse role was 'extremely influential' in CCG decision making and the remaining 41.7% (n=5) thought that it was 'fairly influential'. Half of respondents (50%, n=6) felt that they were always able to get the CCG board meetings to deal with issues which they considered important; a further 41.7% (n=5) said that they could do so 'nearly always' and the remaining 8.3% (one respondent) said that they could do so 'sometimes'. 54.5% of respondents (n=6) -were extremely satisfied with the contribution they make to the CCG and the remaining 45.5% were fairly satisfied. However it should be noted that this perceived efficacy is self-assessed and it would seem, at the current time, there is no data which could independently demonstrate what impact, if any, GBNs actually have on the work of CCGs.

#### Theme 4: Goals of the CCG

Respondents were asked to rank a list of possible CCG goals, from 1 to 5 (one was the highest priority –items with lowest score in the chart below were regarded as the highest priority).

Chart 5: GBNs' perceptions re goals of the CCG



The most important goals of the CCG (from the fixed choice list presented in the questionnaire) were felt to be improving the population's health (mean rank of 1.55), and commissioning and service redesign (2.45 and 3.09 respectively). Meeting financial targets or meeting other targets were considered to be a far lower priority.

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### *Theme 5: Leading nursing/being a leader of nurses*

The degree to which GBNs should or could be a lead for (the profession of) nursing within the CCG locality was a subject the interviewees felt strongly about. As one survey respondent said,

“[She] Brings a consciousness of patient need to every decision whilst at the same time having a strategic overview of the wider population we serve. The secondary benefit to the CCG is that of the "nurturing qualities" of the nurse to a developing, new organization”

Another survey respondent felt that all Board members were leaders for strategic change, while making the point that his role as GBN was to provide an independent (unconflicted) professional voice.

“In my case it does not make a specific nursing contribution - it does however provide a non-medical and an 'unconflicted' clinical voice. It provides challenge and scrutiny on clinical strategies and an overview of quality and safeguarding matters. Importantly, the role also contributes to multi-professional strategic planning” (Survey open question data)

In the survey data there was a suggestion that, in CCGs where there was a part time GBN, there remained a requirement for nursing leadership locally,

“Where the role is part time there is an added awareness that there needs to be further nursing leadership on the board at a senior level as part of the Executive team or as designated nurse”.

Questions in the survey around relationships within CCGs revealed that GBNs' roles and performance were affected by their lack of credibility as clinical leads,

“A recent discussion where the CCG was still challenging my role as a 'clinical' leader with the ability to lead clinical workstreams. I really thought we had got beyond the 'it is only about GPs' but clearly it will be a constant battle!”

## DISCUSSION

The findings from the three phases are synergistic and provide a picture of the backgrounds, experiences of the GBN role now, including their confidence in working in the role, and some of the challenges they consider to be important in the role as it develops. The key challenges include the differences in the different types of roles of GBN working and how these influence CCG decision making, performance and the achievement of the transformation agenda and recently, how the GBN role will shape or be shaped by collective leadership proposed in the Five Year Forward View (DH 2014).

In the context of current DH policy, the distinction between part time/non-executive GBNs and full-time/executive GBNs is important as it raises issues around who is taking on these roles and what the implications for succession planning might be of part time GBN roles, and how effective such a part time role can be in terms of leading nursing.

Another key finding is that the relationship between GBNs and local nurses might need some support, in particular those with provider DoNs and nurses in CSUs, who are possibly one source of recruitment for future GBNs. This raises the conundrum identified in the data over whether GBNs are acting as leaders for change or leaders for nursing and nurses. The participants in this study had different views about this which raises some interesting questions about the nature of professional identity and cohesion which may be threatened by organisational structures and new roles such as commissioning imposed on nurses by the design of health services. In terms of leadership for change perhaps it is significant that the study participants (from Phase 2 and 3) did not appear to critically examine the whole change context in which

CCGs have come into being. This has involved the passage of the Health and Social Care Act and the consequent structural change within the NHS. It has brought with it increased emphasis on the purchaser/provider split, more providers coming from outside the NHS and the decentralisation of health care decision-making. In terms of their nurse leadership role, there appears also to be little focus on the current lack of resources within the NHS and the possible effect on their quality assurance roles of cuts.

The findings also show that it is possible to combine or have separate statutory and designated roles but that these may give rise to tensions between working at operational and strategic levels. CCGs work very differently to each other which may have implications for nursing identity and professional cohesion, education and practice; ~~Each~~each different context may be important in a 'fearful culture' post Francis Inquiry.

### Limitations

The literature review section has a notable absence of primary empirical studies relating to the experiences of nurses on CCGs. This is partly because CCGs have only been in place since April 2013, with a prior year of 'shadow' CCGs, so that there has been little time for research in this field. ~~Other limitations include: a) the~~The sample was drawn from London and therefore might not ~~necessarily~~ be generalisable to the national context – however it was a ; b) ~~the small size of the qualitative sample may have made disclosure less likely and may have threatened the anonymity of the respondents, despite every effort being made to protect this; c) the survey was a pilot survey so this limitation was, to some extent, inevitable. There is a and a~~



national need for a national survey is required – using random sampling in order to assess the national picture accurately. The small size of the sample (for both the quantitative and qualitative research) may have threatened the anonymity of the respondents (despite the best efforts of the researchers to protect this) and so may have made disclosure less likely.

## Conclusions

In this pilot study we used qualitative and quantitative methods to explore GBNs' roles and experiences on CCGs. Our findings suggest that the respondents work in one of two main GBN models: a full time role which combines an executive nurse function with the statutory nurse member role and a part time non-executive role statutory nurse member role. Both types of role largely hold similar remits i.e. quality assurance. They feel confident in their roles as they consider they have the seniority and experience required but there is very little evidence to support this in terms of population outcomes and/or board functioning, as we know very little about how such senior nurses effect change or contribute to organisational functioning (Burdett 2006). Their influence on CCG decision-making is self-assessed, and other roles on the CCG might have different views about the importance or impact of the GBN. The different GBN role models – part time versus full time – should be explored in the context of the effectiveness of each in leading nursing and service redesign. Our data suggest that while there are claims to leadership of nursing and/or nurses by GBNs in CCG localities, this also needs further research. In addition, further work around succession planning needs to be undertaken, taking into account age, gender and ethnicity diversity.

Two other key findings require further ~~research; namely~~research; namely relationships with other local senior nurses, in particular directors of nursing in provider trusts, practice nurses, public health nurses and nurses working in CSUs. The findings suggest that such relationships require maintenance and that a shared nursing identity and professional cohesion might be threatened by organisational redesign.

Lastly, GBN roles have emerged at a time of both a) organisational change with the introduction of new ways of working in the NHS (2010), and b) in a period following extensive criticism of nursing and nurses in the media – a milieu which our participants described as ‘post Francis’ [Inquiry]. These two ‘events’ present contextual challenges to the success of GBN roles.

### **Recommendations**

1. There is a need to monitor nursing roles and developments within CCGs with a view to evaluating their impact and how they shape decision making and the inclusion or exclusion of part time GBNs. There is a need for support and research into GBNs leadership role both within CCG Boards and within the locality.
2. There is a need to strengthen senior nurse cohesion across CCGs despite the ‘artificial’ divisions which commissioning may impose.

Two further papers in this series explore findings from a national survey by NHS England into GBN’s experiences and an interview based study into GBNs’ experiences of their leadership role.

## References

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